tion of seeking what is in the PVS patient's best interests.

Finally I would emphasise my principal argument which focuses on the need for clear decision making in PVS, LPT decisions. Existing judgments do not - and cannot - deliver this until relevant criminal, civil, medical, ethical and moral issues are openly debated. Undoubtedly all concerned - doctors, family, nursing staff, lawyers and judiciary - seek the best outcome for the patient. However, the appropriate mechanistic tools are needed to allow decisions to be taken with that objective in mind. Recent judicial semantics and reconstructions show that, in England and Scotland at least, courts are not suitably equipped. A broader, empowered judicial function is therefore needed. Open debate of these issues is the essential first step towards meeting the genuine best interests of patients in this tragic, highly personal situation.

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ANDREA J FENWICK
*Department of Private Law, University of Edinburgh, Old College, South Bridge, Edinburgh EH8 9YL*


## Editor's response

The debate between philosophy, ethics and law is one of the ever more flourishing developments in medical ethics. If Ms Fenwick's assertion is accurate that lawyers and judges have concluded that where an agent foresees death to be the "virtually certain" consequence of his action the agent *may* be inferred to possess criminal intention; and if this, as she implies, means the agent *must* be inferred to possess criminal intention; and if "actions" include cessation of action (including withdrawals of trials of treatment); then the law is indeed an ass and required the modification that the House of Lords decision in Bland produced. But if we move away from these legal arguments, there seems nothing contorted or illogical in philosophy, ethics or medical ethics in arguing, as I did, that if a doctor foresees a patient's death as being inevitable as a result of that doctor's action or inaction, this in no way *entails* that the doctor intended that death. That question depends, unsurprisingly, on the doctor's intention! There was no need for Bland's doctors to intend the death of their PVS patient when they ceased providing non-beneficial interventions, even though they foresaw that it was inevitable. Similarly a doctor carrying out cardiopulmonary resuscitation (CPR) need not, and normally does not, intend the death of the patient when he stops the CPR, even though he foresees the inevitable cessation of circulation and consequent death that will follow, if the CPR has failed to evoke a spontaneous heartbeat.

## Euthanasia in the Netherlands

SIR

Dr Ryan bases his attack[1] on the validity of the "slippery slope" concept on the 1996 paper of van der Maas *et al.*

A careful examinaton of the data are not so reassuring. While Dr Ryan is concerned only with non-voluntary euthanasia, there are other data which are also problematic, and their plateau may not yet have been reached. By van der Maas's figures there was a 48% increase in cases of active euthanasia over a five-year period. The authors presented the data in terms of a change from 1.7% to 2.4% and indeed an increase of 0.7% seems minimal. But this increase of 0.7% is a 48% increase and represents over 1,000 additional deaths due to active euthanasia, with no obvious explanation. Whereas in 1990 27-32% of requests for euthanasia were acceded to, this increased to 36-38% in 1995. Some physicians, like myself, interpret the data as an all too ready use of euthanasia to solve difficult patient care problems.

But, in addition, as Dr Ryan himself states: "perhaps the damage was done in the first ten years that the Dutch allowed euthanasia". Indeed much of current practice is in unequivocal violation of the strict guidelines that the Dutch advocates themselves articulated very clearly when they first proposed their system, and when they assured us that these rules were to be inviolate. These rules were: patient initiation of request; absolute voluntarism; severe suffering; consultation with another physician, and honest and full reporting to the authorities. The widespread violation of these self-imposed restrictions indeed occurred in the first years of the present system.

As one Dutch physician told me in response to the question of how it felt directly to kill a patient: "The first time it was difficult".

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SHIMON GLICK MD
*Jakobovits Center of Jewish Medical Ethics, Ben Gurion University of the Negev, Israel*


## Greek theories on eugenics

SIR

Professor David Galton has written an interesting article on the Greek theories on eugenics, reviewing the works of Plato and Aristotle.[1] Some more aspects would probably be worthwhile mentioning:

1. Plato's suggestions were not limited to healthy persons reproducing but in preventing the sick and malformed citizens bearing children as well. Such offspring would most probably be as wretched as their parents[2] and should not be reared.[3]
2. Beyond infanticide of the unwanted progeny, Plato's suggestions included abortion[4] and transmission to the "other city".[5] The latter proposal has led scholars to deny that infanticide was really meant by Plato and probably this passage and not the mentioned one from Herodotus[1] led the late Professor Francis Galton to make the comment about the formation of colonies.
3. Morbid genetic material would not only have been undesired by the state but would inhibit individual evolution as well[6] providing a bad quality of life.[7] Although it sounds

strange for current ethics, Plato seemed somehow to act for the "patient's best interests".

4. Plato realised very well the controversy (quite prominent nowadays) between individual and state interests and the difficulties in accepting his model.[8] Furthermore he realised that more eugenics issues would potentially evolve, but hoped that educated citizens would cope sufficiently with them.[9]
5. A major Greek achievement was the rationalisation of the physiology and pathology of inheritance, as described by Aristotle.[10] Nowadays, after the Mendelian laws and the genome mappings, this probably seems of less importance; however, the Romans, for example, considered malformed newborns as ominous monsters (*prodigia*).[11] Yet, it should be remembered how superstitiously malformations such as cleft lip were treated until very recently.
6. Greek theories were not only manifested in the state models of Plato and Aristotle; even Cynicism included eugenic suggestions, such as having children from union with the handsomest women.[12] Yet, it was not only theories and teachings: the legislation of Sparta, as preserved by Plutarch,[13] reminds one quite well of the blueprint of Plato's model.

As Greeks based virtue equally on physical, mental and social wellbeing, they were reluctant to separate the good from the beautiful and individual value from submission to the community. Therefore, they would seemingly accept, more or less, the idea of eugenic manipulation. However, there was not any kind of consensus and as Professor David Galton emphasises, even in Plato's works there seems to be a differentiation from *The Republic* to *Laws*. Greek theories are really valuable when exploring analogous contemporary ethical problems, but even Plato himself would not equate the "philosopher king" with the chairman of a twentieth century eugenics board.[14]

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E GALANAKIS MD, PHD(PHIL)
*Department of Paediatrics, University of Crete, Greece*

# Students' opinions on the medical ethics course in the medical school curriculum

SIR

Medical ethics is introduced as a mandatory course in the University of Zagreb Medical School curriculum. The course is held during the sixth (last) year of the MD programme. It is administered by the multidisciplinary board and taught by various professionals (practising physicians, experts in ethics, a lawyer, a theologian etc). The duration of the course is 30 teaching hours. Lectures on general medical ethics are delivered at the beginning and followed by discussions on special ethical topics (transplantation, abortion, assisted conception, genetic counselling, privacy of medical information, death and life-prolonging treatment etc).

The course was attended by a class of 217 students in their sixth year and was followed by an anonymous poll. Questions were designed by the board and intended to evaluate the contents of the course, its goals, timing and teachers. The majority of the students assessed the course as useful. They expressed the opinion that medical ethics would help them to identify ethical issues in their future work and to increase their feelings of responsibility regarding ethical aspects of medical practice.

Nevertheless, a narrow majority of students (54.4 %) expressed the opinion that a separate course of medical ethics was not necessary; it would suffice to integrate ethical contents into other courses of the medical curriculum. The majority of students have stressed that in their view practical aspects of the course did not meet their expectations. Students have described as inadequate the opportunity to confront practical ethical issues during the course.

We have been surprised by the attitude expressed by students that no formal course on medical ethics is necessary as they prefer medical ethics to be taught in the ward within other medical specialties. Similar arguments against a formal course in medical ethics were encountered by Hope[1]: "Some said that ethics was being taught, not as a formal course but on ward rounds in the context of discussing individual patients".

As teachers of medical ethics, we feel that a formal course is necessary as a tool for the introduction of general principles of ethics and its multidisciplinary aspect. Medical ethics is not exclusively an area of physicians' competence. In their practical work future physicians will be supported by an increasing number of ethical committees. Often these committees are multidisciplinary and include various professionals.[2] A formal course of medical ethics could be designed so as to offer an opportunity for students to meet in person ethicists, lawyers, theologians and other professionals dealing with ethical issues in medical practice.

The association of ethical issues with clinical medical practice seems to be the priority of medical students polled. Students preferred (94.5%) medical practitioners as their teachers in medical ethics. We have also observed that students seemed to be deeply touched when encountering certain ethical problems during their daily medical practice. Sometimes, to the surprise of medical teachers, during general medical courses, ethical aspects of patient care attract the attention of medical students more than strictly medical issues. The proposed core curriculum model for the teaching of medical ethics allows its full integration into the curriculum, consistently forging links with good medical and surgical practice.[3] Ethical issues in medical practice can reach far beyond the delivery of health care and introduce students to humanity and charity as part of their profession.